Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

BAYSHORE MEDICAL CENTER
c/o HOLLAWAY & GUMBERT
3701 KIRBY DRIVE, SUITE 1288
HOUSTON TX 77098-3926

Respondent Name

TEXAS MUNICIPAL LEAGUE INTERGOVERNMENTAL RISK

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-06-7326-01

MFDR Date Received

JULY 31, 2006

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per Rule 134.401(c)(6)(A)(i)(iii), once the bill has reached the minimum stop-loss threshold of $40K, the entire admission will be paid using the stop-loss reimbursement factor ('SLRF') of 75%...Therefore, reimbursement for the entire admission including charges for items in (c)(4) is calculated by the stop-loss reimbursement factor stated in the ACIHFG, **i.e.,** 75%. Furthermore, separate reimbursement for items listed under Rule 134.401(c)(4) is improper and illegal when the amount of the claim is $40,000.00 or greater."

Amount in Dispute: $19,685.23

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Requestor asserts it is entitled to reimbursement in the amount of $39,809.23, which is 75% of the total charges."

Respondent's Supplemental Position Summary Dated February 13, 2013: "Respondent submits this Respondent's Post-Appeal Supplemental Response as a response to and incorporation of the Third Court of Appeals Mandate in Cause No. 03-07-00682-CV…Based upon Respondent's initial and all supplemental responses, and in accordance with the Division's obligation to adjudicate the payment, in accordance with the Labor Code and Division rules, Requestor has failed to sustain its burden of proving entitlement to the stop-loss exception. The Division must conclude that payment should be awarded in accordance with the general *per diem* payment in accordance with 28 Texas Administrative Code §134.401 (repealed)…"

Responses Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
August 8, 2005 through August 26, 2005	Inpatient Rehabilitation Hospital Services	$19,685.23	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Former 28 Texas Administrative Code §134.401, effective August 1, 1997, provides for the reimbursement guideline for acute care inpatient hospital services.
3. Former 28 Texas Administrative Code §134.1, effective May 16, 2002, sets forth general provisions related to medical reimbursement.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W10-Payment based on fair & reasonable methodology.
   - 175-Services have been previously paid
   - W4-No additional payment allowed after review.
   - B13-Payment for service may have been previously paid.

Findings

1. Former 28 Texas Administrative Code §134.401(a)(2) states "Psychiatric and/or rehabilitative inpatient admissions are not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline on these specific types of admissions."
2. This dispute relates to inpatient rehabilitation hospital care services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, which requires that, "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. Former 28 Texas Administrative Code §133.307(g)(3)(D), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor's position statement asserts that "Per Rule 134.401(c)(6)(A)(i)(iii), once the bill has reached the minimum stop-loss threshold of $40K, the entire admission will be paid using the stop-loss reimbursement factor ('SLRF') of 75%...Therefore, reimbursement for the entire admission including charges for items in (c)(4) is calculated by the stop-loss reimbursement factor stated in the ACIHFG**, i.e.,** 75%."
   - The requestor seeks reimbursement based upon 28 Texas Administrative Code §134.401(c)(6). Per 28 Texas Administrative Code §134.401(a)(2) the disputed services are not subject to reimbursement per former 28 Texas Administrative Code §134.401(c)(6).
   - The requestor did not support position that additional reimbursement of $19,685.23 would be a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by

the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

		11/14/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.